Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
CHEMICAL DEPENDENCY Article 3.51-9, Texas Insurance Code; Sections 3.8001-3.8030, Subchapter HH, Title 28, Texas Administrative Code SAME FOR HMO & A&H	HMO & A&H: Benefits for the necessary care and treatment of chemical dependency must be provided on the same basis as other physical illnesses generally. Benefits for treatment of chemical dependency may be limited to three separate series of treatments for each covered individual but must be in accordance with the standards adopted under 28 TAC §§3.8001 - 3.8030. HMO: Applicable to any group evidence of coverage. A&H: Applicable to any group policy providing basic hospital, surgical or major medical expense	303.90: Alcohol Dependence. 304.40: Amphetamine Dependence. 304.30: Cannabis Dependence. 304.20: Cocaine Dependence. 304.50: Hallucinogen Dependence. 304.60: Inhalant Dependence. 304.00: Opoid Dependence. 304.90: Phencyclidine Dependence. 304.10: Sedative, Hypnotic, or Anxiolytic Dependence. 304.80: Polysubstance Abuse Dependence.	
DIABETES: EDUCATION & SUPPLIES Articles 21.53D & 21.53G, Texas Insurance Code Sections 21.2601-21.2607, Subchapter R, Title 28, Texas Administrative Code	HMO: Any EOC that provides benefits for treatment of diabetes and associated conditions must provide coverage to each qualified enrollee for diabetes self-management training programs. The coverage must be in accordance with the standards adopted under 28 TAC §§21.2601-21.2607. A&H: Medical or surgical expense polices which provide benefits for treatment of diabetes and associated conditions must provide coverage to each qualified diabetes self-management training programs. The coverage must be provided in accordance with the standards adopted under 28 TAC §§ 21.2601 - 21.2607 NOTE: This also includes diabetes supplies & meds. HMO: Applicable to any individual or group evidence of coverage. Not applicable to an EOC issued to a small employer. A&H: Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer	250.xx: Diabetes mellitus (excluding 250.3x- diabetic coma)	99078: Physician educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions). 99071: Educational supplies, such as books, tapes, and pamphlets, provided by the physician for the patient's education at cost to physician. NOTE: Glucose monitors, test strips, needles, syringes, and other diabetic equipment, as well as medications, will not be captured on claims forms, rather these expenses will be calculated through a PBM or retail pharmacy.

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
HEARING SCREENING FOR CHILDREN Article 21.53F, Texas Insurance Code SAME FOR BOTH	HMOs: Any EOC/policy that provides benefits for a family member of the enrollee/insured must provide coverage for each covered child for: (1) a screening test for hearing loss from birth through the date the child is 30 days old, as provided by Chapter 47, Health and Safety Code; and (2) necessary follow-up care related to the screening test from birth through the date the child is 24 months old. Benefits may be subject to copayment/coinsurance requirements, but may not be subject to a deductible requirement or dollar limits. These limitations and requirements must be stated in the EOC/policy. HMOs: Applicable to any individual or group evidence of coverage. Not applicable to an EOC issued to a small employer. A&H: Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer	NOTE: Age Specific: birth-24 months V20.2: Routine infant or child health check, which includes Routine vision and hearing testing. NOTE: Necessary follow-up care related to screening test = treatment. 389.0x: Conductive hearing loss 389.1x: Sensorineural hearing loss 389.2: Mixed conductive and sensorineural hearing loss 389.7: Deaf mutism, not elsewhere classified 389.8: Other specified forms of hearing loss 389.9: Unspecified hearing loss	
IMMUNIZATIONS HMOS: Articles 21.53F, and 20A.09F, Texas Insurance Code Sections 11.506(2) & 11.508(a)(9)(G), Subchapter F, Title 28, Texas Administrative Code A&H: IMMUNIZATIONS - Article 21.53F, Texas Insurance Code	HMOs: Any EOC that provides benefits for a family member of the enrollee must provide coverage for each covered child from birth through the date the child is six years old for (1) immunization against diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; varicella; and rotovirus; and (2) any other immunization that is required by law for the child. Immunizations may not be subject to a deductible or copayment requirement. A&H: Policies that provide benefits for a family member of the insured shall provide coverage for each covered child from birth through the date the child is six years old for: (1) immunization against diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella; and (2) any other immunization that is required by law for the child. Immunizations may not be subject to a deductible, copayment or coinsurance requirement HMOs: Applicable to any individual or group evidence of coverage. Not Applicable to an EOC issued to a small employer. A&H: Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.		NOTE: Codes 90471-90474 must be reported in addition to the vaccine and toxoid code(s) 90476-90749. 90471: Immunization administration; (includes percutaneous, intradermal, subcutaneous, intramuscular, and jet injections) one administration (single or combination vaccine/toxoid). 90472: Immunization - each additional vaccine. (use in conjunction with 90471). 90473: Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid). 90474: Each additional vaccine (use in conjunction with 90473). 90645-90648: Hemophilus influenza b vaccine (Hib) 90700-90703: Diphtheria, tetanus, and/or pertussis. 90704-90710: Measles, mumps &/or rubella 90712-90713: Poliovirus 90716: Varicella 90719: Diptheria toxoid 90720: Diptheria, tetanus, pertussis, & Hib (DTP-Hib) 90721: Diptheria, tetanus, pertussis & Hib (DtaP-Hib) 90723: DtaP-HepB-IPV 90744: Hepatitis B vaccine, pediatric/adolescent dosage 90748: Hepatis B & Hemophilus influenza b (HepB-Hib) 90680: Rotavirus NOTE: Immunizations required by law will be different throughout the state and each school district may have different requirements

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
MAMMOGRAPHY HMO: Articles 20A.02(b) & 20A.09E, Texas Insurance Code Chapter 11, Subchapter F, Title 28, Texas Administrative Code A&H: Article 3.70-2(H), Texas Insurance Code	HMO: Required under basic care/well woman exam. A&H: Annual screening by low-dose mammography for females 35 years old or older must be provided on the same basis as other radiological examinations. HMO: Applicable to any individual or group evidence of coverage assuming mammography is part of basic care A&H: Applicable to any individual or group policy.	NOTE: This is age specific beginning at 35 for indemnity/PPO. V76.11: Screening mammogram for high-risk patient V76.12: Other screening mammogram	76092 – Screening mammography
RECONSTRUCTIVE SURGERY INCIDENT TO A MASTECTOMY HMO: Article 21.53I, Texas Insurance Code Section 11.508(a)(5)(A), Subchapter F, Title 28, Texas Administrative Code A&H: Reconstructive Surgery Incident to a Mastectomy - Article 21.53I, Texas Insurance Code	HMO & A&H Any EOC or policy that provides benefits for mastectomy must provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to achieve a symmetrical appearance; and (3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy. The coverage may be subject to co-payments that are consistent with other benefits under the EOC or policy, but may not be subject to dollar limitations other than the policy lifetime maximum for A&H. HMO: Applicable to any individual or group evidence of coverage A&H: Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses, including cancer policies	174.x: Malignant neoplasm of female breast 175.x: Malignant neoplasm of male breast	19318: Reduction mammaplasty (for symmetry). 19324(-19325): Mammaplasty, augmentation; without prosthetic implant (with prosthetic implant) (for symmetry). 19340: Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction. 19342: Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction. 19350: Nipple/areola reconstruction. 19357: Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion. 19361: Breast reconstruction with latissimus dorsi flap, with or without prosthetic implant. 19364: Breast reconstruction with free flap. 19366: Breast reconstruction with other technique. 19367(-19368): Breast reconstruction with transferse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;(with microvascular anastomosis. 19369: Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site. 19380: Revision of reconstructed breast. 19396: Preparation of moulage (wax model) for custom breast implant.

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
ORAL CONTRACEPTIVES Section 21.404, Subchapter E, Title 28, Texas Administrative Code	HMO: Any EOC must provide benefits for oral contraceptives when all other prescription drugs are covered. A&H: Benefits for oral contraceptives must be provided when all other prescription drugs are provided. HMO: Applicable to any individual or group evidence of coverage that provides coverage for prescription drugs. A&H: Applicable to any individual or group policy providing coverage for prescription drugs.		
OSTEOPOROSIS, DETECTION AND PREVENTION Article 21.53C, Texas Insurance Code SAME FOR HMO & A&H	HMO & A&H : Any EOC or policy that provides benefits for medical or surgical expenses incurred as a result of an accident or sickness must provide coverage to qualified enrollees for medically accepted bone mass measurement to determine the enrollee's risk of osteoporosis and fractures associated with osteoporosis. (Group coverage only; requires strict qualifications). HMO: Applicable to any group evidence of coverage. A&H: Applicable to any group policy that provides benefits for medical or surgical expenses.	V82.81: Osteoporosis Screening	
PHENYLKETONURIA (PKU) Article 3.79, Texas Insurance Code SAME FOR HMO & A&H	HMOs & A&H : Any EOC or policy that provides benefits for prescription drugs must include formulas for treatment of PKU or other heritable diseases. HMO: Applicable to any group evidence of coverage that provides coverage for prescription drugs. A&H: Applicable to any group policy which provides coverage for prescription drugs	270.1: PKU NOTE: PKU is only one of a number of heritable diseases requiring special nutritional formulas.	NOTE: Only claims paid for the **cost of nutritional formulas** required by those with PKU or other heritable disease that require special nutritional formulas should be reported. Claims for the evaluation and treatment of patients should not be included as a cost related to this mandated benefit.

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
PROSTATE CANCER TESTING HMO: Articles 21.53F & 3.50-4, Sec. 18D, Texas Insurance Code Section 11.508(a)(9)(E), Subchapter F, Title 28, Texas Administrative Code A&H: Article 21.53F, Texas Insurance Code TRS:	HMOS: Any EOC that provides benefits for diagnostic medical procedures must provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer. Minimum benefits must include: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is at least 50 years of age and asymptomatic; or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.An evidence of coverage offered under the Texas Public School Employees Group Insurance Act must provide coverage for a medically accepted prostate specific antigen test for each male who is at least 50 years of age or at least 40 years of age with a family history of prostate cancer or another cancer risk factor. A&H: Policies that provides benefits for diagnostic medical procedures must provide coverage for each male enrolled in the plan for expenses incurred in conducting an annual medically recognized diagnostic examination for the detection of prostate cancer. Minimum benefits must include: (1) a physical examination for the detection of prostate cancer; and (2) a prostate-specific antigen test used for the detection of prostate cancer for each male enrolled in the plan who is: (a) at least 50 years of age and asymptomatic; or (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor. A policy offered under the Texas Public School Retired Employees Group Insurance Act must provide coverage for a medically accepted prostate specific antigen test for each male who is enrolled in the plan and at least 50 years of age or at least 40 years of age with a family history of prostate cancer or another cancer risk factor HMO: Applicable to any individual and group evidence of coverage. Not applicable to an EOC issued to a small employer. TRS part applicable to any EOC offered under the Texas Public School Employees Group Insurance Act. A&H: Applicable to any individual, group, blanket, or franchise insurance policy that provides benefits for		84152-84154: PSA direct, total, & free NOTE: The TIC has age specifications of 50 for all males and 40 for males with a family history.

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
PROSTATE CANCER TESTING (Cont.)	medical or surgical expenses. Not applicable to a policy issued to a small employer. TRS part applicable to any policy offered under the Texas Public School Retired Employees Group Insurance Act		
PSYCHIATRIC DAY TREATMENT FACILITY HMO: Article 3.70-2(F), Texas Insurance Code Sections 11.509(5) & 11.510(3), Subchapter F, Title 28, Texas Administrative Code A&H: Article 3.70-2(F), Texas Insurance Code	HMOs: An EOC that provides benefits for treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Determination of EOC benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or in-patient program. On rejection of mandated benefits the HMO must offer and the enrollee can select an alternative level of benefits, however, any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in hospital facilities. A&H: A policy providing benefits for treatment of mental illness in a hospital must include benefits for treatment in a psychiatric day treatment facility. Determination of policy benefits and benefit maximums will consider each full day of treatment in a psychiatric day treatment facility equal to one-half day of treatment in a hospital or in-patient program. On rejection of mandated benefits the insurer shall offer and the policyholder can select an alternate level of benefits, but any negotiated benefits must include benefits for treatment in a psychiatric day treatment facility equal to at least one-half of that provided for treatment in hospital facilities HMO: Applicable to any group evidence of coverage that provides coverage for mental illness. A&H: Applicable to any group policy providing mental illness coverage (primarily major medical and hospital/medical/surgical coverage	NOTE: This benefit refers to either intensive outpatient (IOP) or partial hospitalization in either a free standing psychiatric facility or an acute care hospital with a day psychiatric program. Treatment would be rendered in 2-8 hours so the admission and discharge fields on the claims forms would have to be noted in order to gather this data. Further, treatment for mental, emotional, or nervous disorders that may be covered in this setting could include a vast list of diagnosis codes, including all codes for serious mental illness.	

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES IN A CHILD Article 21.53W, Texas Insurance Code SAME FOR HMO & A&H	HMO & A&H Any EOC or policies that provide benefits to a child who is younger than 18 years of age must define "reconstructive surgery for craniofacial abnormalities" in the EOC or policy to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. Any EOC must provide coverage for reconstructive surgery for craniofacial abnormalities for a child who: (1) is younger than 18 years of age; and (2) has maintained continuous coverage from the date of birth in accordance with laws relating to portability. HMOs: Applicable to any individual or group evidence of coverage. Not applicable to an EOC issued to a small employer. A&H: Applicable to any individual, group, blanket, or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer.	NOTE: Age specific to a child less than 18 years of age.	21076(-21088): Impression and custom preparation; surgical obturator prosthesis (orbital, interim obturator, definitive obturator, mandibular resection, palatal augmentation, palatal lift, speach aid, oral surgical, auricular, nasal, facial prostheses). 21089: Unlisted maxillofacial prosthetic procedure. 21100: Aplication and removal of halo 21110: Application and removal of interdental fixation device for conditions other than facture or dislocation. 21120-21123: Genioplasty; augmentation 21125-21127: Augmentation, mandibular body or angle; prosthetic material. 21137-21139: Reduction forehead. 21141-21147: Reconstruction midface, LeFort I. 21150-21151: Reconstruction midface, LeFort II. 21554-21560: Reconstruction midface, LeFort III. 21172: Reconstruction superior-lateral orbital rim and lower forehead. 21175: Reconstruction, bifrontal, superior-laterial orbital rims & lower forehead. 21179-21180: Reconstruction, entire or majority of forehead and/or supraorbital rims. 21181: Reconstruction by contouring of benighn tumor of cranial bones, extracranial. 21182-21184: Reconstruction orbital walls, rims, forehead, nasoethmoid complex. 21188: Reconstruction midface, osteotomies (other than LeFort type) and bone grafts. 21193-21196: Reconstruction of mandibular rami. 21198(-21199): Osteotomy, mandible, segmental; (with genioglossus advancement.) 21206: Osteotomy, maxilla, segmental. 21208(-21209): Osteoplasty, facial bones; augmentation (reduction). 21210 (& 21215): Graft, bone; nasal, maxillary or malar areas; includes obtaining graft (mandible). 21230 (& 21235): Graft; rib cartilage, autogenous, to face, chin, nose or ear; includes obtaining graft (ear cartilage, autogenous, to nose or ear). 21244: Reconstruction of mandible, extraoral, with transosteal bone plate. 21245 (-21246): Reconstruction of mandible or maxilla, subperiosteal implant; partial (complete). 21247: Reconstruction of mandibular condyle with bone and cartilage autografts). 21248 (-21249): Reconstruction of mandible or maxilla,

Mandated Benefit	Description	ICD-9	CPT Codes
RECONSTRUCTIVE SURGERY FOR CRANIOFACIAL ABNORMALITIES IN A CHILD (Cont.)			endostreal implant; partial (complete). 21255: Reconstruction of zygomatic arch and glenoid fossa with bone and cartilage. 21256: Reconstruction of orbit with osteotomies and with bone grafts. 21260-21263: Periorbital osteotomies for orbital hypertelorism. 21267-21268: Orbital repositioning, periorbital osteotomies, unilateral, with bone grafts. 21270: Malar augmentation, prosthetic material. 21275: Secondary revision of orbitocraniofacial reconstruction. 21280: Medial canthopexy. 21282: Lateral canthopexy. 21295-21296: Reduction of masseter muscle and bone. 21299: Unlisted craniofacial and maxillofacial procedures 62115-62117: Reduction of craniomegalic skull. 62140-62141: Cranioplasty 62142 (-62143): Removal of bone flap or prosthetic plate of skull (replacement of bone flap or prosthetic plate of skull.) 62145: Cranioplasty for skull defect with reparative brain surgery. 62146-62147: Cranioplasty with autograft (includes obtaining bone grafts). 67950: Medial canthoplasty
SERIOUS MENTAL ILLNESS HMO Articles 3.51-14, 3.50-2 Section 5(j)(2), 3.50-3, Section 4C(2), and 3.51-5A(a)(2), Texas Insurance Code Section 11.509(5), Subchapter F, Title 28, Texas Administrative Code HMO Small Emp Plans cite: Article 3.51-14, Texas Insurance Code Section 11.509(5), Subchapter F, Title 28, Texas Administrative Code A&H: Articles 3.51-14, 3.50-2, 3.50-3 & 3.51-5A, Texas Insurance Code	HMO: A group EOC: (a) must provide coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (c) must include the same amount limits, and deductibles for serious mental illness as for physical illness. The Texas State Employees Uniform Group Insurance Plan may not provide benefits for serious mental illness that are less extensive than the minimum coverage required by Article 3.51-14, Texas Insurance Code. Benefits for serious mental illness must not be less extensive than benefits for any other physical illness. Texas State College and University Employees Uniform Insurance Benefits Act – Article 3.50-3, Section 4C(2) Local Governments – Article 3.51-5A(a)(2)	293.81-293.83: Organic delusional, hallucinosis, and affective Syndromes 295.xx: Schizophrenic Disorders (xx=modifiers defining specific types of schizophrenia) 296.xx: Depressive & Bipolar Disorders 297.xx: Paranoid States (Delusional Disorders) 298.xx: Other non-organic Psychoses 299.xx: Pervasive Developmental Disorders 300.4: Neurotic Depression 301.13: Cyclothymic disorder 311: Depressive Disorder not elsewhere classified	

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
SERIOUS MENTAL ILLNESS (Cont.) For A&H small emp plans, cite is Article 3.51-14, Texas Insurance Code	HMO Small An HMO issuing coverage to a small employer must offer, and the small employer shall have the right to reject, coverage for serious mental illness that complies with the following requirements: (a) coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) the coverage may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (c) the coverage must include the same amount limits, and deductibles for serious mental illness as for physical illness. A&H: A group policy (a) must provide coverage for 45 days of inpatient treatment, and 60 visits for outpatient treatment, including group and individual outpatient treatment coverage, for serious mental illness in each calendar year; (b) may NOT include a lifetime limit on the number of days of inpatient treatment or the number of outpatient visits covered under the plan; and (c) must include the same amount limits, deductibles, and coinsurance factors for serious mental illness as for physical illness - Article 3.51-14. HMO: Applicable to any group evidence of coverage. (Only a mandated offer under an EOC offered to a small employer.) Applicable to any EOC offered under the Texas State Employees Uniform Group Insurance Benefits Act – Article 3.50-2, Section 5(j)(2), Texas Insurance Code. Applicable to specific government employee benefit plans. HMO Small: Applicable to any EOC issued to a small employer. A&H: Applicable to any group policy that provides benefits for medical or surgical expenses. (Note: Mandated Offer for a policy issued to a small employer.) Applicable to any policy offered under the Texas State Employees Uniform Group Insurance Benefits Act – Article 3.50-2. Applicable to the specific governmental employee policy referenced.		

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
TELEMEDICINE/ TELEHEALTH HMO:Article 21.53F, Texas Insurance Code Section 11.1607(i), (j) & (k), Subchapter Q, Title 28, Texas Administrative Code A&H: Article 21.53F, Texas Insurance Code	HMO & A&H::An EOC or policy may not exclude a telemedicine medical service or a telehealth service from coverage solely because the service is not provided through a face-to-face consultation. Telemedicine medical services and telehealth services may be subject to a deductible or copayment requirement; however, the deductible or copayment may not exceed the amount that is required for a comparable medical service when provided through a face-to-face consultation. HMO: Applicable to any individual or group evidence of coverage. Not applicable to an EOC issued to a small employer. A&H: Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer	NOTE: Telemedicine/telehealth services could be used to diagnose/treat almost any diagnosis. Texas law defines telehealth and telemedicine services as follows: "Telehealth service" means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facscimile, including: (A) compressed digital interactive video, audio or data transmission; (B) clinical data transmission using computer imaging by way of still-image capture and store and forward; and (C) other technology that facilitates access to health care services or medical specialty expertise. "Telemedicine medical service" means a health care service initiated by a physician or provided by a health professional acting under physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including: (A) compressed digital interactive video, audio or data transmission; (B) clinical data transmission using computer imaging by way of still-image capture and store and forward; and (C) other technology	There are no unique CPT codes that specifically identify telemedicine services. Commercial plans will need to develop a method for specifically identifying claims for telemedicine/telehealth services. This may involve a review of multiple claims data fields. The following information describes how telemedicine services are reimbursed for Texas Medicaid providers and may be helpful for identifying commercial claims. All codes with a prefix modifier of GT (for General Telemedicine or live telemedicine) or GS for store forward (taping a telemedicine encounter and sending it at a later date). Hub site providers may only be reimbursed for consultations via interactive video using procedure codes 3-99241 through 3-99275 billed with the GT modifier. Remote site providers may be reimbursed for an office visit (POS1) using codes 1-99201 through 1-99215 or encounter codes in POS1 or 5 as applicable, 1-Z9813 (Federally Qualified Health Center), 1-Z9202 (Rural Health Clinic), 1-Z9100 (Rural Health Clinic), 9-Y0011 (Rural Health Clinic), and B-W0004 (Rural Health Clinic). If prolonged physician services 1-99354 and 1-99355 or special services 1-99050, 1-99052, and 1-99054 are provided in addition to a telemedicine office visit (1-99201 through 1-99215), these services should also be billed with the GT modifier.

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
TELEMEDICINE/ TELEHEALTH (Cont.)		that facilitates access to health care services or medical specialty expertise.	
TEMPOROMANDIBULAR JOINT (TMJ) HMO: Article 21.53A, Texas Insurance Code Section 11.509(6), Subchapter F, Title 28, Texas Administrative Code A&H: Article 21.53A, Texas Insurance Code	HMO: Any EOC that provides benefits for diagnostic or surgical treatment of skeletal joints must provide comparable coverage for diagnostic or surgical treatment of conditions affecting the temporomandibular joint that is necessary due to (1) an accident; (2) a trauma; (a) a congenital defect; (4) a developmental defect; or (5) a pathology. A&H: A group policy that provides benefits for the medically necessary diagnostic or surgical treatment of skeletal joints must provide comparable coverage for the diagnosis or surgical treatment of conditions affecting the temporomandibular joint that is necessary as a result of: (1) an accident; (2) a trauma; (a) a congenital defect; (4) a developmental defect; or (5) a pathology (General note: A plan does not have to cover dental services before these benefits are available, nor may it exclude coverage for someone unable to undergo dental treatment in an office setting or under local anesthesia due to a "documented physical, mental or medical reason" determined by the doctor or dentist.) HMO: Applicable to any individual or group evidence of coverage. Not applicable to an EOC issued to a small employer. A&H: Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to a policy issued to a small employer	524.6x: Temporomandibular joint disorders. 830.0-830.1:Dislocation of jaw including temporomandibular joint 848.1: Other and ill-defined sprains and strains jaw, temporomandibular (joint).	21010: Arthrotomy, temporomandibular joint. 21050: Condylectomy, temporomandibular joint. 21060: Meniscectomy, partial or complete, temporomandibular joint. 21116: Injection procedure for temporomandibular joint arthrography + 70332: Temporomandibular joint arthrography, radiological supervision and interpretation. 21240: Arthroplasty, temporomandibular joint, with or without autograft (includes obtaining graft). 21242: Arthroplasty, temporomandibular joint, with allograft. 21243: Arthroplasty, temporomandibular joint, with prosthetic joint replacement. 21480 (& 21285): Closed treatment of temporomandibular dislocation; initial or subsequent (complicated). 21490: Open treatment of temporomandibular dislocation (+ 21497: Interdental wiring for condition other than fracture). 21141-21147: Reconstruction midface, LeFort I. 21150-21151: Reconstruction midface, LeFort II. 21154-21160: Reconstruction midface, LeFort III.
IN VITRO FERTILIZATION HMO: Article 3.51-6, Section 3A, Texas Insurance Code Section 11.510(1), Subchapter F, Title 28, Texas Administrative Code A&H: IN-VITRO FERTILIZATION - Article 3.51-6, Section 3A, Texas Insurance Code	HMO: Unless rejected in writing by the group contract holder, any EOC providing coverage for pregnancy-related procedures must offer and make available coverage for outpatient expenses that may arise from in-vitro fertilization procedures. A&H: Unless rejected in writing by the group policyholder, benefits for in-vitro fertilization must be provided to the same extent as benefits provided for other pregnancy-related procedures subject to certain requirements HMO: Applicable to any group evidence of coverage.	628.x: Infertility, female	89250: In-Vitro Fertilization.

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
IN VITRO FERTILIZATION (Cont.)	A&H: Applicable to any group policy providing coverage on an expense incurred basis (primarily major medical and hospital/medical/ surgical coverages)		
SPEECH AND HEARING HMO: Article 3.70-2(G), Texas Insurance Code Section 11.510(2), Subchapter F, Title 28, Texas Administrative Code A&H: Article 3.70-2(G), Texas Insurance Code	HMO: An HMO shall offer, and the group contract holder shall have the right to reject, coverage for the necessary care and treatment of loss or impairment of speech or hearing that is not less favorable than for physical illness generally. The group contract holder may select an alternative level of coverage if the HMO offers such coverage. A&H: Unless rejected by the group policyholder or an alternative level of benefits is negotiated, benefits must be provided for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally. HMOs: Applicable to any group evidence of coverage. A&H: Applicable to any group policy providing coverage on an expense incurred basis (primarily major medical and hospital/medical/ surgical coverages.	V72.1: Examination of Ears and Hearing	92507-92510: Speech & Hearing Therapies 69930: Cochlear Device Insertion. 69710: Hearing aid hormone pellet(s) bone conduction. Audiologic Function Tests with Medical Diagnostic Evaluation (all descriptors refer to testing both ears. Modifier .52 if a test is applied to one ear only): 92551-92553 92555-92557 92559-92565 92567-92569 92571-92573 92575-92577 92579 92582-92599
HIV, AIDS, OR RELATED ILLNESSES HMO: Article 3.51-6, Section 3C, Texas Insurance Code A&H - Articles 3.51-6, Section 3C; 3.51-6D; 3.50-2, Section 5(j)(1); 3.50-3, Section 4C(1); and 3.51-5A(a)(1), Texas Insurance Code; Section 3.3057(d), Exhibit A, Subchapter S, Title 28, Texas Administrative Code	HMO & A&H : An EOC or policy may not exclude, deny, or cancel coverage for HIV, AIDS, or HIV-Related illnesses. HMO A&H: Applicable to any group evidence of coverage. A&H: Applicable to any individual or group policy (primarily major medical and hospital/medical/ surgical coverages). Individual may exclude.	042: HIV Infection Type 1 (including AIDS) 079.53: HIV Type 2 V08: Asymptomatic HIV infection status 136.3: Pneumocystosis 795.71: Nonspecific serologic evidence of HIV	
COLORECTAL CANCER TESTING HMO and A&H: Article 21.53S, Texas Insurance Code	HMO & A&H: An EOC or policy that provides benefits for screening medical procedures must provide coverage for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal	V10.0: Personal history of malignant neoplasm, Gastrointestinal tract V12.72: Personal History of Colonic polyps V16.0: Family history of malignant neoplasm, Gastrointestinal tract	45378: Colonoscopy, flexible 45380: Colonoscopy, with biopsy, single or multiple 45330 Sigmoisoscopy, flexible 45331 Sigmoidoscopy, with biopsy, single or multiple 82270: Blood, occult, by perioxidase activity (eg guiac), quaitative, feces, 1-3 simultaneous determinations.

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
COLORECTAL CANCER TESTING (Cont.)	cancer. An insured must have the choice of at least one of the following: (1) a fecal occult blood test preformed annually and a flexible sigmoidoscopy performed every five years, or (2) a colonoscopy performed every 10 years. A&H: applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses. Not applicable to policy issued to a small employer. HMO: Applicable to any individual or group EOC. Not applicable to an EOC issued to a small employer.	V76.5: special screening for malignant neoplasms, Intestine V76.41: special screening for malignant neoplasms, rectum	
ACQUIRED BRAIN INJURY (ABI) HMO and A&H: Article 21.53Q, Texas Insurance Code	HMO and A&H: An EOC or policy may not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioural, neurophysiological, neuropsychological and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury. Coverage may be subject to deductibles, copayments, and annual or maximum payment limits that are consistent with other similar coverage under the EOC or policy. HMO: Applicable to any group or individual EOC. A&H: Applicable to any individual, group, blanket or franchise insurance policy that provides benefits for medical or surgical expenses, including an accident policy.	Diagnosis Codes for Acquired Brain Injury include a large number of codes associated with both physical and psychological illnesses and injuries. Identification and reporting of claims related to the ABI mandate will generally require a variety of data elements in order to accurately limit claim reporting to only those claims subject to the ABI mandated benefit requirement. **Please note that the mandate only addresses coverage of specific therapy and intervention services and does not include medical services for treatment of the actual head injury. Thus, claims reported will not include all costs associated with these diagnosis codes, but only those costs related to the required therapy, testing and treatment as described in the mandated benefit description (previous column).** Following is a list of ICD-9 Diagnosis Codes potentially associated with the ABI mandate, but not necessarily inclusive: 191's: Brain Neoplasm 310.2: Post-Concussive Syndrome 320-326: Inflammatory diseases 343.9: Acquired Cerebral Palsy 348: Brain Lesions, Other conditions of the brain	CPT Codes for Acquired Brain Injury include a large number of codes associated with various forms of treatment that are provided to patients other than those with Acquired Brain Injury. As such, care must be taken to identify only those claims provided to insureds diagnosed with Acquired Brain Injury. Identification and reporting of claims related to the ABI mandate will generally require a variety of data elements in order to accurately limit claim reporting to only those claims subject to the ABI mandated benefit requirement. Following is a list of CPT codes that may potentially identify services provided to those with ABI. **However, reported claims costs should not include any of these services unless they were provided as a result of an acquired brain injury.** 90901: Biofeedback 90911: Biofeedback training 90875: Individual psychophysiological therapy incorporating biofeedback 90801-90899: Psychophysiological testing and treatment 92507: Speech Therapy 92585: Auditory Evoked Response 95925-95930: Somatosensory evoked potential studies 95961-95962: Functional cortical and subcortical mapping 95812, 95819: Neurofeedback therapy 96100-96117: CNS assessment 97001-97799: Physical/occupational therapy 97530: Therapeutic activities 97532: Development of Cognitive skills 97533: Sensory integration 97535: Self care/home management 97537: Community/work reintegration 99301-99380: Evaluation and Management codes

Texas Mandated Benefit ICD/CPT Codes

Mandated Benefit	Description	ICD-9	CPT Codes
ACQUIRED BRAIN INJURY (ABI) (Cont.)		430-438: Cerebrovascular disease 436: Stroke, CVA 519.8: Airway Obstruction 780.0: Altered consciousness 780.39: Seizures 799.0: Hypoxia 800-804: Skull Fracture Injuries 847.10: Cervical Trauma Syndrome 850-854: Intercranial Injury, concussions 873.8 Open Head Injury 905.0, 907.0, 907.1: Late effects of injuries to the Nervous System 924.9: Contusion 950.9: Post Traumatic Vision Syndrome 959.01: Head Injury, Traumatic Brain Injury, Mild Closed Head Injury 977.9: Toxic Drug Ingestion 980.9: Toxic ETOH Ingestion 989.9: Toxic Chemical Ingestion 994.1: Near Drowning 995.55: Shaken Baby Syndrome V57: Rehab Procedures	